

#### Accident Investigation, Human Factors, and Safety:

A lifetime of passion

Robert Sumwalt Membre Associé Etranger, AAE





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2 Sextines - 56 Pages

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Frider, December 21, 1972.

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Air Crash

Flood Of Bills Sent To Nixon

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# 10-Gallon

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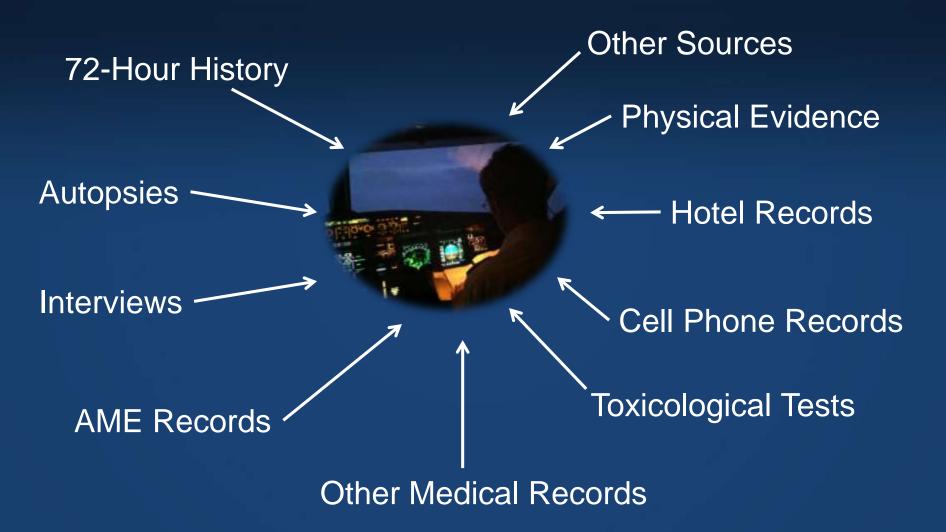




Human factors is a multidisciplinary science that examines the relationship between humans and the systems with which they interact, including...

Engineering Psychosocial interactions Ergonomics TEM **Decision-making** Fatigue Psychology **Physiology** Human-centered design Biomechanics Information processing National cultural influences Study of organizational issues Medicine Anthropometrics CRM Automation management Resilience engineering Communications

#### **Potential Sources of Information**



NTSB Investigations Examine the Entire System



Interface with Machine & Environment

Corporate and Regulatory Environment

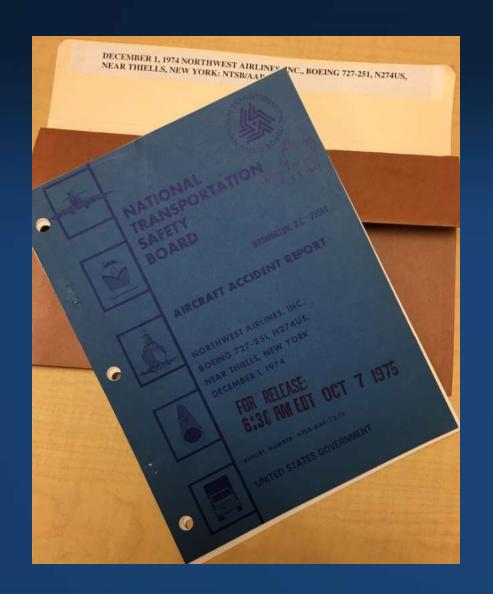
# TRAINED FOR LIFE: HUMAN-CENTERED APPROACH TO SAFETY

#### **System Safety Order of Precedence\***

- 1. Eliminate the hazard through Design/Engineering Features
  - Hazard is corrected and eliminated
- 2. Incorporate Guards/Safety Devices
  - Guards put up to decrease exposure
- 3. Provide Warning Devices
  - Warn personnel if you can't eliminate or control the hazard
- 4. Develop Procedures and Training

ROBERT'S HF PREMISE # 1

If you design out the problem, you design out the problem. <duh>





#### ROBERT'S HF PREMISE # 2

If you design something with enough complexity, don't be surprised if someone can't use it when they really need it.

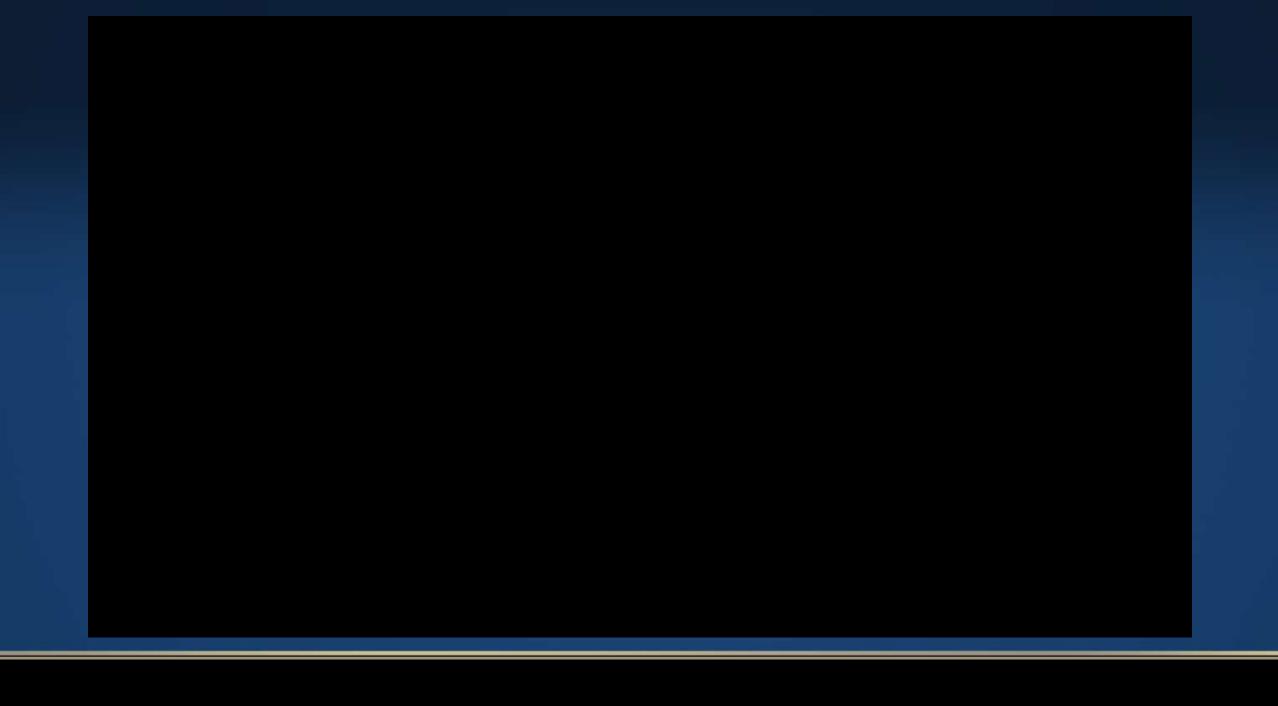
#### American 383, October 28, 2016





Rejected takeoff

Evacuation







ROBERT'S HF PREMISE # 3

If you don't account for human error, you, yourself, have made a very basic human error.



# Loss of Control at Takeoff

Frisco, Colorado July 3, 2015 CEN15MA290

# **NTSB Finding**

 "The design of Airbus Helicopters dualhydraulic AS350-series helicopters <u>did not</u> <u>account for the possibility of pilot error</u> in configuring the tail rotor hydraulic circuit ..."

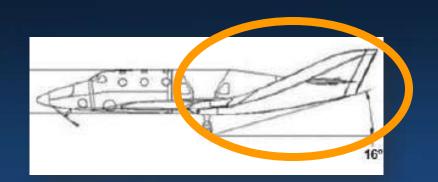
#### In-Flight Breakup During Test Flight

October 31, 2014

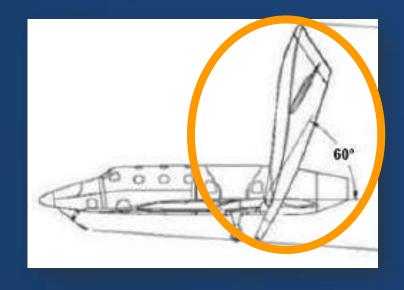




### SpaceShipTwo Feather System

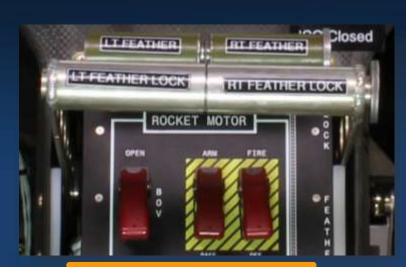


Feather retracted

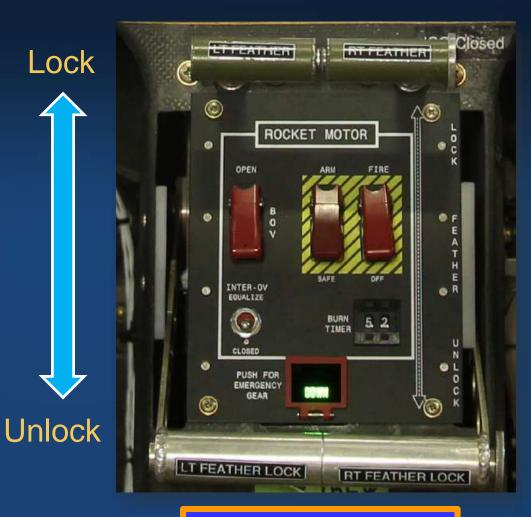


Feather extended

#### **Feather Lock Handle**



Feather Locked



Feather Unlocked

#### The investigation found

- High emphasis on making sure feather was unlocked at 1.4 Mach.
  - Cockpit visual and aural alerting
  - Training and procedures
  - Mission abort if not unlocked by 1.8 Mach
- Not great concern placed on low speed unlocking.
  - Relied on pilots to do it right

#### **Specified Flight Crew Procedures**

#### PILOT

Action: Vehicle control Verbal command: "Fire"

> Action: Trim stabilizer

WK2 release

0.8 Mach

Transonic bobble

1.4 Mach

#### COPILOT

Action: Ignite rocket motor

> Verbal call: "0.8 Mach"

Verbal call: "Stabs (degrees)"

Action: Unlock feather

- A single-point mechanical failure with catastrophic consequences would be unacceptable.
- However, Scaled Composites failed to consider that a single human error could be catastrophic.

## **NTSB Finding**

"By not considering human error as a potential cause of uncommanded feather extension on the SpaceShipTwo vehicle, Scaled Composites missed opportunities to identify the design and/or operational requirements that could have mitigated the consequences of human error during a high workload phase of flight."

#### **NTSB** Recommendation



Develop and issue human factors guidance for use during the design and operation of crewed vehicles.

